Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MED FAMILY MEDICINE AND REHAB

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 11, 2013

MFDR Tracking Number
M4-14-1067-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...the claim denied for Provider not approved to treat Texas Star Network Claimant. We were told many ties our facility Ace Pain Management & Rehab Tax ID [tax id number] was in the Texas Star Network, so we started to bill claims under our new facility. But we have encountered denials for several patients because our Tax ID [tax id number] was not in the network. The first time claims were denied we submitted a Reconsideration which it was denied for the same reason."

Amount in Dispute: $138.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This claim is in Texas Mutual's Texas Star Network. See Exhibit 1. Therefore, the matter cannot be reviewed in medical dispute resolution. There is no evidence that the out-of-network service was approved by the Network. The requestor is not a participating health care provider in Texas Mutual's Network under the TIN billed and is no evidence that the out-of-network service was approved by the Network."

Response Submitted by: Texas Mutual Insurance Company

DISPUTED SERVICES SUMMARY

Dates of Service	Disputed Services	Amount In Dispute	Amount Ordered
April 1, 2013	99213	$138.12	$0.00

BACKGROUND

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.

FINDINGS AND DECISION

Issue

1. Did the requestor receive a referral approval from the certified network to treat the injured employee?
2. Is this dispute eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307?

Findings

The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation is to apply Texas Labor Code statutes and rules, including 28 TAC §133.307, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305. In particular, TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation." The requestor therefore has the burden to prove that the condition(s) outlined in the Texas Insurance Code §1305.006 were met in order to be eligible for dispute resolution. The following are the Division's findings.

1. Texas Insurance Code Section 1305.006 requires, in pertinent part, that "(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103."

   Texas Insurance Code Section 1305.103 requires, in pertinent part, that "(e) A treating doctor shall provide health care to the employee for the employee's compensable injury and shall make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by the network..."

   The requestor has the burden to prove that it obtained the appropriate network approved referral for the out-of-network healthcare it provided. Review of the submitted documentation finds that the requestor submitted insufficient documentation to support that a referral was obtained from the treating doctor and approved by the network to treat the injured employee, thereby failing to meet the requirements of Texas Insurance Code Section 1305.103(e).
2. The requestor failed to prove in this case that that the requirements of Texas Insurance Code Section 1305.006(3) were met. Consequently, the services in dispute are not eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

DECISION

Based upon the documentation submitted by the parties, the Division has determined that this dispute is not eligible for resolution pursuant to 28 Texas Administrative Code §133.307.

Authorized Signature

Signature	Medical Fee Dispute Resolution Manager	**October 30, 2014** Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.